Nutritional Issues in Long-Term Care: Research Findings and Practice Implications

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Goals for Today

- Overview of Risk Factors
- What works? Research Evidence
- How do you make it happen? Care Practice
- Challenges & Strategies - Staffing
Risk Factors for Under-Nutrition, Dehydration and Weight Loss

- Advanced age
- Sensory impairments (smell, taste, hunger, thirst)
- Dietary restrictions (no salt, puree)
- Medications (decrease in appetite)
- Physical and cognitive impairment
- Need help with eating
  - Physical help
  - Verbal cueing and reminders

- Typical LTC resident - multiple risk factors
Poor Nutritional Status is Common

- 10% to 20% unintentional weight loss – MDS
  - 5% in 30 days or 10% in 180 days

- 50%-70% of residents often have inadequate food and fluid intake, which increases risk of:
  - Under nutrition
  - Dehydration
  - Skin breakdown, delayed wound healing
  - Hospitalization
  - Mortality
What can you do to improve nutritional status of residents?

- Amount and quality of assistance with meals
- Offer additional foods & fluids between meals
- Two most effective ways to get residents to eat and drink more
- Impact nutrition, hydration and weight status
Mealtime Assistance – What works?

- It doesn’t work for everyone: 40%-50% of those who eat poorly will eat significantly more with extra staff time and attention during meals.

- Residents need at least 15-20 minutes of staff attention – most receive less (average < 10 min).

- Residents can be grouped together (1:3) to allow staff to provide assistance more time efficiently.

- Multiple types of staff can help during meals.
Mealtime Assistance – What works?

- Many Types of Assistance – Multiple Types of Staff:
  - Physical (spoon-feeding)
  - Set Up (opening containers, cutting up meat)
  - Verbal reminders & encouragement ("How is your breakfast this morning?" "Why don’t you try another bite of soup?")
  - Offers of alternatives, extra helpings, substitutions
Identification of Poor Eaters: Estimating Meal Intake

- “Total percent eaten” documentation for meals typically over-estimates intake by an average of 20% or more

- The lower the intake of residents, the greater the over-estimate

- Many reasons for estimation error
  - Limited staff time and many, competing tasks
  - Trays get taken away too soon
  - Complicated estimation rules
  - Supplements counted as part of meal
Oral Intake Estimation: Strategies to Improve Accuracy

- Clinically meaningful: Does resident consume more or less than half of served meal?

- Supplements should not be served with or count as part of meal

- All served items (foods + fluids) should count equally

- Designated staff member(s) for intake documentation separate from those providing assistance

- Trays left longer – also helps slow eaters

- Group dining in dining room or other common area
The Advantages of Group Dining

- Residents who eat in the dining room:
  - More accurate intake documentation
  - Higher food and fluid intake
  - Receive more staff assistance to eat
  - Receive more socialization during the meal
  - Receive offers of alternatives to the served meal

- Minimally, at-risk residents should be encouraged to eat at least 2 meals/day in the dining room

- Allows residents in need of assistance to be grouped together for more time-efficient care delivery (1:3)
Another Approach: Between-Meal Snacks

- Most (80%) at-risk residents will increase their total daily caloric intake with snacks, including those not responsive to mealtime assistance.

- Offer additional foods and fluids 2-3 times/day between meals (morning, afternoon, evening).

- Variety of snack options including, but not limited to, supplements.

- Assistance and encouragement is still important (requires an average of 5-10 minutes per person).

- Residents can be grouped together for snacks (1:4-6).
Another Approach: Between-Meal Snacks

- Organized, social group activities – opportunity for offering snacks

- Coordination with kitchen to allow for more snack options and easy access on the unit

- Snack offers between meals for at-risk residents are just as important as meals

- Focus on those who eat poorly during meals – limited staff time usually prohibits offering snacks to everyone
Staffing Strategies
Who Else Can Help?

- Nurse aides alone are often not enough –
  - Meal delivery, set-up and pick-up
  - Transport of residents to/from dining room
  - Delivery of snacks between meals
  - Verbal reminders & offers of alternatives
  - Intake documentation

- Federal and state regulations allows non-nursing staff to be trained to provide feeding assistance

- “All Hands on Deck” approach to mealtime care – trained staff can provide a valuable resource and impact residents’ nutritional status
Share your Experience and Voice your Opinion

- Let Dietary know about residents’ food/fluid preferences
- Tell Supervisory Nurse(s) about possible need for diet changes or swallowing evaluation (e.g., difficulty chewing or swallowing, spitting, coughing)
- Talk to Dietary/Kitchen staff about making alternatives to the served meal and a variety of snacks between meals available and easily accessible on the unit
- Share effective feeding strategies with other staff/across shifts
- Tell Supervisory/Charge Nurse when you need help
Information & Learning Resources

- www.VanderbiltCQA.org “Weight Loss Prevention” Module
  - Learning Resources (CMS-DVD, Training Manual)
  - Assessment forms and guidelines
  - References of published studies
  - Links to Other web-sites

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